January 2000

Closing the Gap

A newsletter of the Office of Minority Health, U.S. Department of Health and Human Services

Moving Toward Consensus on Cultural Competency in Health Care

By Michelle Meadows

Health care organizations have primarily been on their own when it comes to figuring out what cultural competency means. They may use an assortment of definitions and interpretations of cultural competency. For example, a major accrediting agency might focus on the importance of providing interpreter services, while a small physician's practice might spend more time incorporating traditional healing into western medicine.

But new guidance will support a more uniform and comprehensive approach to cultural competency standards and practice. The Office of Minority Health (OMH), U.S. Department of Health and Human Services, recently released 14 draft standards for culturally and linguistically appropriate services (CLAS) in health care. The draft CLAS standards ran in the Federal Register on December 15, 1999, and members of the public can submit comments on the standards until April 30, 2000.

The standards are part of the OMH-funded Cultural and Linguistic Competence Standards and Research Agenda Project, which was conducted by Resources for Cross Cultural Health in Silver Spring, MD, and the Center for the Advancement of Health in Washington, DC.

This project represents a significant move toward the first set of national cultural and linguistic standards in health care delivery, said Guadalupe Pacheco, a special assistant to the director of OMH and the project officer for OMH's cultural competency activities.

It's important to note that the standards are recommendations and not mandates, but the goal is for the recommendations to create a more consistent way of looking at expectations for cultural competency across the country.

"More and more providers are treating a diverse group of patients," Pacheco said, "and providing culturally competent health care facilitates efforts to improve health outcomes and patient satisfaction." Providers and policymakers will now be able to use the CLAS recommendations to create accountability systems that ensure high quality services for diverse populations.

> *"More and more providers are treating a diverse group of patients, and culturally competent care improves health outcomes and patient satisfaction."*

Defining cultural competency

The CLAS project uses a working definition of cultural competency that's an adaptation of a definition cited by the Office of Women and Minority Health in the Bureau of Primary Health Care, Health Resources and Services Administration.

"Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities."

As an example, the CLAS project report describes an elderly Bosnian woman being admitted to a health facility with terminal cancer. She doesn't read, speak, or understand English, her Muslim faith requires modesty during physical exams, and cultural beliefs make her family members shy away from discussing end-of-life matters.

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OFFICE OF PUBLIC HEALTH AND SCIENCE
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Closing the Gap

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"Many providers are looking for guidance on how to respond to these situations appropriately," said Julia Puebla Fortier, principal investigator with Resources for Cross Cultural Health Care. The draft standards will give providers a context for understanding and responding to the role of culture and language in health, she said.

Valerie Welsh, evaluation officer and public health analyst in OMH's Division of Policy and Data, said cultural competence is not just a matter of diversity. "It's one of many factors that affect health care quality," she says, and can even be considered a route to better quality care.

Developing the standards

Staff with Resources for Cross Cultural Health and the Center for Advancement of Health reviewed and compared existing cultural competence standards and measures, proposed the draft language and assessed information and research needs related to these guidelines. This included analyzing key laws, regulations, contracts, and standards used by federal and state agencies, and national organizations.

> *"Many providers are looking for guidance on how to respond to these situations appropriately."*

Researchers found that generally, documents contained more requirements related to linguistic competence than cultural, Fortier said. Other findings were that very few source documents reviewed could be considered comprehensive in terms of the range of cultural competency activities addressed, and a core set of cultural competence activities emerged from the document reviews and helped form the list of draft standards.

The draft standards make several recommendations, including ongoing education and cultural competency training for all levels of staff at health organizations. Another standard recommends using a variety of methods to collect and use accurate demographic, cultural, and epidemiological data for racial and ethnic groups in the service area. A national advisory committee of policymakers, providers, and researchers provided input for the recommended standards.

Call for comments

The 120-day public comment period began on January 1, 2000, which makes the deadline for comments from individuals and organizations April 30, 2000. "Publication in the Federal Register will encourage input from a wide audience of stakeholders," Pacheco says. Final revisions will be published in the Federal Register in the fall of 2000.

Three regional meetings are an important part of the public comment process, and will be held on January 21, 2000 in San Francisco; March, 10 in Baltimore; and April 5 in Chicago. Registration for the one-day meetings, which will allow participants to make comments on the standards and provide feedback, will be on a first come, first served basis. About 150 participants are anticipated at each meeting.

This feedback and other comments on the standards also support OMH's Center for Linguistic and Cultural Competence in Health Care. Developed in 1995, the center is a "center without walls" that addresses the needs of limited English-speaking populations, Pacheco said. The center promotes collaborations and the exchange of information on cultural competency. For example, OMH, along with the New York Academy of Medicine and Resources for Cross Cultural Health, held a meeting on cultural competency in October 1998 for approximately 500 participants.

Those who don't attend the upcoming regional meetings on the new standards are also welcome to comment on the standards, and can do so by writing to CLAS Standards, Office of Minority Health, Rockwall II Bldg., 5515 Security Lane, Suite 1000, Rockville, MD 20852. Or, e-mail comments to OMHRC_standards@Iqsolutions.com

To obtain a copy of the standards and accompanying commentary, plus comment forms, visit the Web site of the Office of Minority Health Resource Center at: http://www.omhrc.gov. ~

Making Cultural Competency Work

Guest Editorial By Diane Adams, MD, MPH

All it takes to see the need for cultural competency in health care is looking around, whether it's looking at the people you work with or the people driving by you in rush-hour traffic. The great variety of race and ethnicity in both urban and rural areas is here to stay. Think of how many people don't look like you, think like you, or talk like you. Now consider how these differences impact basic communication.

The implications for communications in health care can be a matter of life or death. For example, culture and language can affect whether a patient takes a proper dose of medication or even agrees to take medication at all. Not offering appropriate translation services could lead a hospital to misdiagnose the condition of a person with limited English-speaking skills. Distributing a brochure with culturally insensitive health messages can backfire and discourage a person from getting a check-up.

A first step for health care organizations interested in developing a cultural competency program is understanding what cultural competency means in health care. Some mistakenly equate it to cultural diversity or affirmative action. Some think cultural competency is only an issue for mainstream America. But at the crux of the concept is how well health workers of all races can reach, serve, and treat those people that don't look like them, think like them, and speak like them.

The need for culturally competent approaches is important in all health care settings, from managed care organizations to clinics. Here are more tips for integrating cultural competency into your organization.

- Tap into good cultural competency resources. Some organizations rule out cultural competency because they consider it too expensive. Too expensive to buy those training videos or too expensive to bring in a consultant. But many good resources that are free or low-cost can support your efforts. For example, the National Center for Cultural Competence offers a useful checklist called *Getting Started.* The free publication is on the Web: http://www.dml.georgetown.edu/depts/pediatrics/gucdc/cultural.html. Also look for experts who may volunteer time to help you. The Office of Minority Health Resource Center (1-800-444-6472) is a good starting place with its Resource Persons Network of experts who may be able to provide technical assistance as you develop a program.
- Assess your staff's understanding of cultural competency. Use a pre- and post-test as part of staff training. This will help you assess your people and your organization, a requirement for setting goals and identifying staff development needs. When I worked with staff at the Whitman Walker Clinic in Washington, DC, we used a cultural competence inventory that had 12 items. Respondents, which included doctors, nurses, mental health workers, and administrative staff, were asked to rate their level of knowledge in various areas on a scale of 1 to 5, with 1 meaning "no knowledge" and 5 meaning "much knowledge". Examples of items on the questionnaire: "Knowledge of questions to ask when conducting a cultural assessment of patients;" and "Knowledge of family and community influences on health care attitudes and behaviors of various cultural groups."
- Make training reflective of real life. Use guest speakers who can talk about how cultural competency has improved patient outcomes for their organization. Both best practice approaches and input on what kind of challenges to expect will help shape your program. For the Whitman Walker Clinic training, we also used case studies and role play scenarios to get health care workers truly involved.
- Include minorities in leadership roles. It's a simple enough concept, but many times decisions are made for minorities without their involvement. Empower minorities to take on leadership roles with your program's advisory committee or task force on cultural competency.
- Put your organization's plans in writing. Not only are you showing staff that cultural competency requires a real commitment, but a written plan will make everyone in your organization aware of your goals, your approach, and the rationale for your efforts. Look for models that work for organizations similar to yours. The National Black Nurses Association recently developed guidelines for its institute to train nurses on cultural competency.
- Put ideas into action. The National Mental Health Association states it well in its position paper on cultural competency (http://www.nmha.org): Many health systems simply pay lip service to the concept. Some organizations claim to be culturally competent, but don't have appropriate procedures in place to address diversity. Evaluate your current communication vehicles such as printed materials and your telephone system. Assess your target populations and make sure there's a clear communication path for each group.

Dr. Adams is senior medical advisor for the Center for Outcomes and Effectiveness Research, Agency for Health Care Research and Quality, (formerly the Agency for Health Care Policy and Research, HHS). She is currently helping AHRQ create a Web site on cultural competence. Dr. Adams is also editor of the best-selling book, Health Issues for Women of Color: A Cultural Diversity Perspective, *and presented a workshop on cultural competency at the annual meeting of the American Public Health Association in November 1999.*~

Understanding Differences in Customs and Patterns of Thinking

By Judy Leaver, MA, and Catherine Huynh, MSW

The National Mental Health Association (NMHA) has launched a multi-year initiative to increase the organization's cultural competence at the national, state and local levels. The NMHA Board of Directors convened a task force on diversity in 1998, which produced a Cultural Competency Planning Guide to assist Mental Health Associations (MHAs) throughout the country.

This effort is driven by the reality of rapidly changing demographics that require nonprofit groups to move aggressively to reflect the communities they serve. Organizations that fail to do so risk becoming ineffective. This means that boards, volunteers and staff should be representative of diverse groups in their communities.

The NMHA task force determined that cultural competence more inclusively reflects the goals of the organization than does diversity. NMHA's statement of cultural competence includes race, ethnicity, religion, sexual orientation, gender, social groups and disabilities. As the organization moves toward its goal of cultural competence, NMHA's values demand that consumers be significantly represented on boards, staff, and in volunteer pools of MHAs, making real the phrase "nothing about us without us."

Diversity is embedded in the goal of cultural competence, but is just one component of it. Accepting and understanding differences in customs and patterns of thinking in other cultures are tangible ways in which diversity is valued. NMHA and its affiliates are working toward becoming a system that responds to the unique needs of populations whose cultures are different from that which is currently "dominant" or mainstream America.

Mainstream America will very shortly look quite different than it does now, providing the major impetus for organizations and systems to become culturally competent. For example, Asian Americans and Pacific Islanders are the fastest growing segment of the U.S. population and will reach 12 million by the year 2000. In 2005, ethnic minorities will account for 47 percent of the nation's population. Eighty-five percent of those entering the work force will be women, people of color, and immigrants. Non-Hispanic whites, presently 75 percent of all Americans, will shrink to a bare majority by 2050.

NMHA has adapted 14 guiding principles from the Substance Abuse and Mental Health Administration's (SAMHSA) Center for Mental Health Services to provide a context for becoming more culturally competent. These principles guide our organizational goals and recommendations and also provide a framework for what to advocate for in a culturally competent service system.

Mainstream America will very shortly look quite different than it does now, providing the major impetus for organizations and systems to become culturally competent.

Over the next three years, NMHA will provide regular trainings on cultural competence to assist MHA's to prepare them for this new requirement in the reaffiliation process beginning in 2002. In addition, its Consumer Supporter Technical Assistance Center has put out a call for proposals on cultural competence. This involves making cultural competency more representative of the local or regional community. Proposals that address cultural competence with the mental health service delivery system will also be accepted. Each grant recipient will become a study site that will provide other organizations and service providers with models for replication and information about what can be learned and tested. For a copy of the Request for Proposals, contact the Consumer Supporter TA Center at (800) 969-6642, or visit NMHA's Web site http://www.nmha.org/ncstac.

Judy Leaver and Catherine Huynh work within the National Mental Health Association's Consumer Supporter Technical Assistance Center. ~

Tool Kit for Managed Care Organizations

Many immigrants and refugees have to deal not only with our complicated managed care system, but also with anxiety over communication barriers. Having a limited knowledge of English and American culture impacts access, affordability, and continuity of care. A new publication, *Building Linguistic and Cultural Competence: A Tool Kit for Managed Care Organizations and Provider Networks that Serve the Foreign-Born*, helps managed care organizations understand the importance of cultural and linguistic services for patients. The 150-page kit describes how culturally competent care is good for business, and offers a guide to marketing and enrollment, member services, and language services. The kit was produced by the Mid-America Institute on Poverty of the Heartland Alliance for Human Needs and Human Rights in Chicago. Sponsors of the document include the Office of Minority Health, Illinois Department of Health, HHS Bureau of Refugee and Immigrant Services, Sara Lee Foundation, Donald and Shelby Rubin Foundation, and the John D. and Catherine T. MacArthur Foundation.

For ordering information, call Sabrina Robinson, at the Heartland Alliance at 312-660-1342. ~

HRSA Activities on Cultural Competency

The Health Resources and Services Administration (HRSA) is involved in several efforts to promote cultural competency in health care. Such activities include:

- Cultural Competence Committee. The committee provides agency-wide guidance on cultural competence. A major effort of the Committee was developing a chapter on cultural competence in health care for inclusion in the publication *Health Care Rx: Access for All*. This publication was developed as part of the President's Initiative on Race. *Contact:* June Horner, Office of Minority Health (OMH) at (301) 443-2964.
- Cultural Competence Best Practices Project. This project has identified and will develop a publication of the best practices among HRSA grantees that serve various ethnic/racial populations, especially grantees participating in managed care. *Contact:* Tamara Allen, Center for Managed Care, (301) 443-1416.
- National Health Service Corps (NHSC). Funded by HRSA, this program works to address physician shortages in rural and inner-city America. Participants are required to take a training module on cross-cultural issues in medicine. The training explores the impact of patients' cultural beliefs and values on medical practice and the practitioner. *Contact:* Donald L. Weaver, NHSC, (301) 594-4130.
- Cultural Competence Series. HRSA, the Substance Abuse and Mental Health Services Administration and OMH have produced a series of publications for public health and substance abuse workers. The latest is *Responding to Pacific Islanders: Culturally Competent Perspectives for Substance Abuse Prevention*, 1998. *Contact:* Len Epstein, HRSA, (301) 594-4490.
- The Bridges Project. Affiliated with HRSA's HIV/AIDS Bureau, the project uses cultural and linguistic approaches to improve access to HIV services for Asian Americans and Pacific Islanders. Contact: Deborah Parham, HIV/AIDS Bureau, (301) 443-0493.
- Cultural Competence Works Competition. This project identified exemplary cultural competence practices among HRSA grantees, and developed a publication including these practices. Twelve grantees received recognition in a ceremony held January 2000.
- HRSA and SAMHSA Collaboration on Cultural Competence as a Cross-Cutting Issue. Both agencies were named co-leads to address cultural competence as a cross-cutting issue. Contact: June Horner, OMH, (301) 443-2964. ~

New HRSA Publication on Cultural Competence

The Bureau of Primary Health Care, part of HRSA, has developed a new publication on cultural competency. *Cultural Competency: A Journey* provides an overview of cultural competency efforts in the U.S. The publication defines cultural competency and explains the elements that contribute to an agency's ability to become more culturally competent. It also gives examples of programs and health facilities that have made changes to become culturally competent. For more information on HRSA's cultural competency programs or to obtain a copy of the publication, *contact:* the Bureau of Primary Health Care, (301) 594-4100, or browse its Web site at: http://www.bphc.hrsa.gov. ~

National Center Promotes Cultural Competency

By Houkje Ross

Current literature indicates that the majority of work in cultural competence has been focused on practitioners, but very little at the administrative or policy level, said Tawara Goode, project director at the National Center for Cultural Competency (NCCC). Practitioners need resources and administrative support to provide culturally competent care, Goode said. For example, practitioners may know that the best way to provide care to people with limited English proficiency is to have interpretation and translation services. However, there may be no policies, budgetary allocations, or staff training to support these services.

The NCCC works to increase culturally competent services in health care settings. It is a collaboration between HRSA's Maternal and Child Health Bureau and the Bureau of Primary Health Care. Housed within the Department of Pediatrics of the Georgetown University Medical Center, the NCCC is a component of Georgetown University's Child Development Center.

The Center is also involved in promoting the exchange of information on cultural competency issues among children with special health needs and maternal and child health programs at local, state, and national levels. Its Children with Special Health Needs component developed and disseminates of *Promoting Cultural Diversity and Cultural Competency*, a self-assessment checklist for personnel providing services to children with special health needs (see checklist on pp. 6-7).

The Center also has new policy briefs on cultural competency that cover the rationale for cultural competence in primary health care and linguistic competence in primary care delivery systems. Future briefs will address engaging with diverse communities to achieve 100 percent access and 0 disparities, and partnerships for a research agenda on cultural competence in primary health care.

For information on these publications and Getting Started, a guide for planning culturally competent service delivery, contact: NCCC, (800) 788-2066, (202) 687-5387 or visit its Web site at: http://www.dml.georgetown.edu/depts/pediatrics/gucdc. ~

Promoting Cultural Diversity and Cultural Competency:

Self-Assessment Checklist for Personnel Providing Services to Children with Special Health Needs and their Families

This checklist was developed by HRSA's Maternal and Child Health Bureau/Children with Special Health Needs component of the National Center for Cultural Competence. It is for personnel providing health services and supports to children with special health needs and their families and is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. The checklist provides concrete examples of the kinds of values and practices that foster such an environment. *Directions: Select A, B, or C for each item listed below.*

A = Things I do frequently B = Things I do occasionally C = Things I do rarely or never

Physical environment, materials, and resources

_____ 1. I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children and families served by my program or agency.

_____ 2. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency.

_____ 3. When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of children and families served by my program or agency.

_____ 4. When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency.

_____ 5. I insure that toys and other play accessories in reception areas and those which are used during assessment are representative of the various cultural and ethnic groups within the local community and the society in general.

Communication styles

_____ 6. For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

_____ 7. I attempt to determine any familial colloquialisms used by children and families that may impact on assessment, treatment or other interventions.

_____ 8. I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency.

_____ 9. I use bilingual staff or trained volunteers to serve as interpreters during assessment, meetings, or other events for parents who would require this level of assistance.

_____ 10. When interacting with parents who have limited English proficiency I always keep in mind that:

- _____ * limitations in English proficiency is in no way a reflection of their level of intellectual functioning.
- _____ * their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.
- _____ * they may or may not be literate in their language of origin or English.

_____ 11. When possible, I insure that all notices and communiqués to parents are written in their language of origin.

_____ 12. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

Self-Assessment Checklist

Values and attitudes

_____ 13. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

_____ 14. In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.

_____ 15. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children and their parents served by my program or agency.

_____ 16. I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity or prejudice.

_____ 17. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).

_____ 18. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

_____ 19. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).

_____ 20. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest male in families).

_____ 21. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.

_____ 22. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

_____ 23. I accept that religion and other beliefs may influence how families respond to illnesses, disease, and death.

_____ 24. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a disability or special health care needs.

_____ 25. I understand that traditional approaches to disciplining children are influenced by culture.

_____ 26. I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self help skills.

_____ 27. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

_____ 28. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations which are unique to families of specific cultures and ethnic groups served by my program or agency.

_____ 29. I seek information from family members or other key community informants, which will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.

_____ 30. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence.

There is no answer key. However, if you frequently responded "C", you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children and families.

For more information contact: Tawara D. Goode, Georgetown University Child Development Center UAP. Adapted from "Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings" (Revised 1999).

HCFA Study to Determine Best Ways to Reach Latino Beneficiaries

By Houkje Ross

Statistics from the Health Care Financing Administration (HCFA) have shown that the Agency's Medicare handbook for Latino and Hispanic populations is not reaching many beneficiaries. The handbook outlines health plan choices under Medicare and helps beneficiaries choose a plan. There were less than 100 requests for the handbook throughout the U.S. between 1998 and 1999, according to David Miranda, PhD, social science research analyst with HCFA's Center for Beneficiary Services. To pinpoint why Hispanic and Latino beneficiaries are not using the Handbook, HCFA's Center for Beneficiary Services is sponsoring research to assess the needs of these populations.

"We are concerned that vulnerable populations get the information they need to make informed choices," Dr. Miranda said. "We want to make sure they are making the right choices with the information we provide them. The small number of requests for the publication, *Medicare y Ustedes*, prompted us to study whether or not there is a problem," he said.

The study, *Development and testing of Medicare quality performance materials for Hispanic/Latino beneficiaries and the intermediaries serving them*, is being carried out by two private research and consulting companies. Information will be collected on the cultural factors that may create barriers for Hispanics and Latinos and to help HCFA find the most useful information for its beneficiaries.

Focus groups with friends and families

Beneficiaries will be interviewed to gain an understanding of how current Spanish-language health plans are being used. Focus groups will also be held with friends and family members. According to Miranda, this will enable HCFA to learn:

- the context in which Hispanic and Latino beneficiaries think about health care and make decisions;
- when and how these beneficiaries make decisions;
- who is or could be most helpful to Hispanics/Latinos in choosing how to get their health care.

Organizations and agencies that serve as intermediaries will also be interviewed to identify their role in the decision and education process of beneficiaries and to look at how well HCFA is doing in supporting them.

The study will consider the following questions:

- How do preferences compare to those of the general beneficiary population?
- What health care information is of most interest to the above groups?
- How do these preferences compare to those of the general beneficiary population?
- Would providing information to Hispanics/Latinos about diseases in which there are known racial and ethnic disparities make information more meaningful?
- Cultural and linguistic appropriateness and communication of health care information will also be examined.

Questions for this aspect of the study may include:

- What are the culturally and linguistically appropriate ways of communicating with Hispanic/Latino populations?
- What health practices and beliefs influence the communication of health care information to these populations?
- In what ways is cultural and linguistic appropriateness affected by beneficiary characteristics like income, or urban v. rural residence?

The study will review marketing and social science research literature and communication for Hispanic and Latino populations to see if the same principles apply. This will include looking at how culture and language may impact information processing and health and information seeking behaviors.

HCFA will use the results of the study to make policy decisions and to determine whether it should customize the Medicare handbook it sends out to Hispanic and Latino populations. The study will be completed in the next year and a half, according to Dr. Miranda.

For more information, contact: David Miranda, (410) 786-7819.~

National Council on Interpretation in Health Care (NCIHC)

The NCIHC promotes culturally competent professional medical interpretation as a way to support equal access to health care for individuals with limited English proficiency (LEP). The NCIHC works to:

- define and support standards of quality health care for LEPs;
- support standards and a code of ethics for interpreters in health care;
- monitor the development of policies, research, and model practices;
- sponsor a dialogue of diverse voices and interests on related issues.

For more information, contact: NCIHC, 750 Washington Street, NEMC Box 271, Boston, MA 02111.~

Improving Communication Between Federal Project Officers and American Indians

By Houkje Ross

To help project officers at the HHS Substance Abuse and Mental Health Administration (SAMHSA) better interact with American Indians, Sandie Johnson compiled *Lessons Learned*, a list of tips, suggestions, and advice on how to work with these populations. Johnson, a project officer in SAMHSA's Center for Substance Abuse Prevention, has more than 25 years of experience working with American Indians and studied with a Cree Medicine woman for 12 years. Federal project officers manage a range of outreach and evaluation activities, which typically includes managing project budgets and working closely with communities to keep projects on track.

With project site visits to communities, one of the most common mistakes project officers make is asking too many questions early on, Johnson said. That approach is often considered too aggressive for some American Indian populations. "This can be problematic because, as a project officer, it is your job to ask questions" so that you can learn about the status of projects, she said. Johnson suggests project officers first understand their boundaries and wait until the individual becomes more comfortable before asking a lot of questions.

"It is important to note that with so many tribal groups, there are vast differences among the different tribes," Johnson added. But *Lessons Learned* addresses some underlying and universal customs and beliefs.

Some of Johnson's suggestions for federal project officers:

- Read up on recent activities of American Indians that you visit. Before visiting with an American Indian grantee, project officers should read some history of the area, the people, and their culture.
- Keep a clear focus on the purpose of your visit. Asking too many personal or spiritual questions may be offensive. This has to be carefully weighed with the fact that the purpose of your visit is to get answers to your questions about a program. Outline the points you want to know in a letter before the site visit.
- Ask permission and give back to the people. Ask permission before gathering data for a study or program evaluation. This is especially important to practice when seeking to do research. In the Indian world view it is also important to give back to the community, Johnson said. Be sure to share research results with American Indians.

Lessons Learned has been reviewed by several American Indians, including Theda Naw Breast, a Blackfoot woman from Montana who works in the substance abuse field, and Tony Kendrick, of the Indian Health Service, (301) 443-3593.

For more information on Johnson's guidelines, contact her at SAMHSA's Center for Substance Abuse Prevention, (301) 443-5333.˜

Foundation Studies Minority Nurses

The American Nurses Foundation (ANF)—the research and education arm of the American Nurses Association—has been awarded a $140,000 grant from the W.K. Kellogg Foundation of Battle Creek, MI, to study diversity in the nursing workforce. The project will get additional information on the more than 246,000 minority nurses who make up about 10 percent of the nation's approximately 2.65 million registered nurses, and will project the future needs for and potential contributions of minority nurses based on the demographics of the minority nurse population.

"At the turn of the century, one in every four Americans will be Black, Hispanic, Middle-Eastern, or Asian. The need for well-educated nurses is great and employment opportunities are likely to be many," said Hattie Bessent, EdD, RN, the lead investigator for the *National Sample of Minority Nurses*. Although nursing programs emphasize cultural sensitivity, the enrollment of individuals already socialized in the cultural beliefs and customs of a minority group will enrich the nursing community, Bessent said. Well-prepared minority nurses can offer leadership and make a vital impact in the economics of health care, she said.

The survey will make projections for the type of diverse workforce that will be needed in the future; provide the nursing community, educators, clinicians, and researchers information for their future work; and include variables that can be used in future sample surveys of the registered nurse population.

A lack of cultural and linguistic competence among health care professionals and practitioners leads to poor patient assessment and treatment, according to the ANF. Additionally, the rates of patient non-compliance with treatment plans is higher when cultural differences and dynamics have not been addressed in the provision of care.

For more information on the survey, contact: American Nurses Foundation, (202) 651-7048. Or visit its Web site at: http://www.nursingworld.org.˜

Medical Schools Want Help in Providing Cultural Competence Curriculum

By Houkje Ross

Learning how to interview patients and take a medical history is a requirement of all medical schools. Some schools go even further and train students on culture and how it impacts the care they give. For example, Dartmouth/Brown Medical School's "Clinical Experience" class covers cultural beliefs and values, race, ethnicity, and sexual orientation. Dave Osborne, a White student in his third year at the school, said he learned how to work with an interpreter for the many patients from Hispanic and Portuguese backgrounds he encounters.

"It was helpful to learn that it is important to maintain eye contact with your patient and to keep the interpreter in the background. You need to speak directly to your patient," he said. Osborne said the class content on culture was good, but there could have been more.

Some medical schools need to learn how to fit cultural competency into the rest of the medical school curriculum.

AAMC studies culture in medical schools

In late 1997, staff in the Division of Medical Education at the American Association of Medical Colleges (AAMC) began gathering information on the activities in place at medical schools regarding cultural competence curriculum. AAMC's ongoing study aims to find out if medical schools considered it their responsibility to teach cultural competency and to find out what schools needed to do it better, said Deborah Danoff, MD, assistant vice president of AAMC's Division of Medical Education.

So far, AAMC has surveyed 141 medical education programs in the United States and Canada, of which 96 percent responded. Of those who responded, 67 percent indicated that they had some form of teaching on cultural competence already in place. Fourteen percent have plans to introduce the topic. The study also found that:

- At least 86 percent of medical schools provided at least one opportunity in multicultural medicine.
- Seventy-one percent said that multicultural medicine was part of a required course.
- Only one school teaches multicultural medicine as a separately required course.

Survey results also showed that most of the medical schools thought they needed assistance in developing or implementing a cultural competency program, said Dr. Danoff. Approximately 60 percent of schools that already had some form of cultural competency training in place indicated they would like additional help. That figure jumped to 80 percent for the schools who did not have a program in place.

The most commonly requested forms of assistance were information on model programs, faculty development materials, formal teaching materials, and evaluation instruments. Of the schools that don't have a program in place, over 40 percent asked for help in the form of justifying the need for cultural competency training. "This is an indication that some medical schools need to learn how to fit cultural competency into the rest of the medical school curriculum," said Dr. Danoff.

But medical schools soon may not have a choice about including cultural competency in their curriculum. The Liaison Committee on Medical Education (LCME) proposed a standard on cultural diversity that would hold faculty and students accountable for recognizing and dealing with cultures and belief systems and how this impacts perceived health, illness, and responses to various symptoms, diseases, and treatments. LCME is the nationally recognized accrediting authority for medical education programs leading to the medical degree in U.S. and Canadian medical schools. LCME will vote on the adoption of the standard in February 2000.

Although AAMC's survey indicates most medical schools are providing some cultural competence training for students and are asking for assistance, some are questioning whether this is enough. "Most U.S. medical schools are not providing adequate instruction in cultural competency," said Glen Flores, MD, assistant professor of pediatrics and public health at Boston University Schools of Medicine and Public Health. For example, little is known about how to teach cultural issues in medical school. Dr. Flores, who is also a Robert Wood Johnson Minority Medical Faculty Development Scholar, is writing a research paper on cultural competency curricula in medical schools, to be published in the spring of 2000.

AAMC continues to gather information on cultural competence efforts at medical schools. The association will collect information from course directors on cultural competency programs or courses in place at medical schools, identify model programs, and share techniques for implementation with other schools. From the data it collects, AAMC hopes to write a summary paper, develop an expertise list, resource materials, and a professional development workshop.

For more information on the project, contact: Dr. Deborah Danoff, Assistant Vice President in the Division of Medical Education, AAMC, (202) 828-0982. ~

AHRQ Grants $4 Million Toward Elimination of Health Disparities

By Houkje Ross

The Agency for Health Care Research and Quality (AHRQ), recently announced it will award over $4 million in fiscal year 2000 to support grants that will establish "Centers of Excellence." The centers will identify practical tools and strategies to eliminate racial and ethnic disparities in the health care system, according to the Agency.

A major purpose of the centers will be to improve the communication between researchers and minorities. The grants fall under HHS' Initiative on Eliminating Racial and Ethnic Disparities and the Surgeon General's Healthy People 2010 Goal to eliminate disparities in health.

Asking the Right Questions

When providers and researchers don't understand the cultural subtleties of the minority groups they serve, the care they provide may suffer, said Daniel Stryer, MD, medical officer for outcomes and effective research at AHRQ (formerly known as the Agency for Health Care Policy and Research). Designing research that is relevant to minority patient's lives is an important step toward eliminating the health disparities seen in these groups. One way to ensure better research is to ask questions in a way that will make sense in the context of the patient's life, Stryer said.

For example, a patient from Mexico may have traveled many times between her native country and the United States. When researchers ask the question, "When did you come to this country," they need to consider the complexities of the patient's life. They have to take into account that the patient may have lived between the two countries for several years before settling in the States.

"What do you really mean when you ask the question? Do you want to know when the patient *first* came to this country? Do you need to know when the majority of the patient's household income came from this country?" Dr. Stryer asked.

"Researchers need to make sure they know why they are asking their question and that they are asking in a way that will get them the information they need."

The Centers will bring together experienced and new researchers to share facilities, services, knowledge, and other resources. Researchers will work with partners and communities to conduct and translate research into practice.

Not only is this an effective way to develop new talent and an efficient way to do research, but it is also a good way to develop and sustain relationships between providers and patients, Stryer said

The range of questions that may be addressed under these grants is broad, according to AHRQ. Issues could include health literacy, access, preferences, clinical management and decision making, quality of care, financing, or service delivery.

Research could address many questions, such as: What patient and provider characteristics are associated with failure to receive recommended preventative screening?

AHRQ Centers of Excellence will also work to strengthen the links between researchers and change agents as a way to eliminate health disparities. Change agents include private or public policy makers, community health centers, workplace and union-based clinics, practice networks, professional organizations on the national and local level, religious and social groups, and the media.

For more information on AHRQ's grant opportunities, contact: Daniel Stryer (301) 594-4039.

AAMC's Minority Medical Education Program

AAMC has a Minority Medical Education Program (MMEP) that offers summer educational experiences for Black, Hispanic, American Indian/Alaskan Native, and Native Hawaiian students. These four groups make up 20 percent of the general U.S. population, but represent only six percent of U.S. physicians.

The MMEP provides practical educational experiences through a six-week summer enrichment program designed to help students compete successfully for acceptance into medical school. Applicants must:

- be a U.S. citizen or hold a permanent visa;
- have completed at least one year of college;
- have an overall grade point average of 3.00, with at least a 2.75 in the sciences;
- have combined SAT or ACT scores of at least 950 or 20; and
- demonstrate a serious interest in a career in medicine.

The deadline for the Summer 2000 MMEP program is April 3, 2000. For an application, contact: AAMC, 2450 N Street, NW, Washington, DC 20037; (202) 828-0400. Or visit its Web site: http://www.aamc.org.

Report from AHRQ

Researchers in AHRQ's Center for Organization and Delivery Studies are in the process of writing a paper on cultural competency. Expected to be completed this winter, the paper presents a conceptual model of how cultural competency can reduce health disparities; describes incentives (and disincentives) for organized health systems to become culturally competent; and reports on strategies to accomplish that aim.

For more information, contact: Cindy Brach, Health Policy Researcher, Agency for Health Care Research and Quality, at: (301) 594-6816; cbrach@ahcpr.gov.

Creating Culturally-Sensitive Health Materials for American Indians

By Jean Oxendine

Brochures on breast cancer from local clinics weren't effective for many American Indian women from the Zuni Pueblo, Hopi, and Navajo tribes in the four corners region of Arizona, Utah, Colorado, and New Mexico. So the women took charge and developed a project from 1997 to 1998 to create culturally-sensitive breast health educational materials.

"We needed to take into account Native beliefs, so we held focus groups, conducted interviews, and held an art contest to develop the most appropriate brochures and posters for the American Indian women in this part of the country," said Judith Luebke, PhD, professor of health sciences at Minnesota State University at Mankato. Dr. Luebke led the breast health project, along with Catherine Offutt, who specializes in health promotion/disease prevention at the Gallup Indian Medical Center in New Mexico.

"Often, American Indians are lumped together as if they are all one group with similar thoughts, ideas and customs."

Getting input from the target group

Focus groups took place in nine locations throughout the region, and lasted for three hours at a time. A total of 72 women, ranging in age from 15 to 85, participated in the sessions, with a facilitator leading the group. Group members reviewed breast cancer educational brochures from six different organizations and evaluated the brochures in terms of content and art. And in cases where women did not speak English, arrangements were made to have interpreters.

Results of the focus groups showed that tribal affiliation is very important, and cultural beliefs regarding health are essential. For example, women wanted a focus on breast *health* and not breast *cancer*; eight of the nine focus groups thought that it was inappropriate to have a breast on the cover of the brochure. Focus group participants also wanted brochures that represent Southwestern art. Most responses also indicated the women wanted the breast cancer brochures with updated and realistic images of women. "They felt that the existing brochures depicted all women looking like Barbie," Luebke said.

The project also used a questionnaire with basic questions about the health of the individual and her family in an effort to start people thinking about what they can do to prevent illness and treat those illnesses from which they are suffering. They also asked questions about previous mammograms, where to go for treatment, financing the exams and treatment, and research.

Attracting artists with a contest

Advertisements for a contest to obtain art for the brochure were placed in local newspapers, on radio stations, and in flyers. The contest attracted 120 American Indian artists, ages 12 to 25. Of the 120 entrants, five winners were chosen and each received a $1000 award. As the artists developed the new brochure and posters, they considered responses to the questionnaires regarding size, color, layout, content, diagrams, and Native artwork.

The final product, an educational brochure called, "Pathways to a Healthy Life: Breast Cancer Awareness," is sponsored by the Susan G. Komen Breast Cancer Foundation, with input and assistance from Offut and women's health coordinators from the Navajo Nation, Hopi Tribe, Indian Health Service, and the New Mexico Breast and Cervical Cancer Program.

Obtaining final feedback

This project was not an easy undertaking, Luebke said. A major challenge: There are 450 tribes and approximately 2 million American Indian people in the United States today. And often, American Indians are lumped together as if they are all one group with similar thoughts, ideas, and customs. Fortunately, many American Indian women liked the new brochure and posters and said they could relate to it to a much greater degree. In fact, American Indians from tribes outside of the four corners region said they could also relate to the materials.

After the brochures were completed, the project team evaluated whether the Indian women would now take better care of their breast health as a result of the brochure. They gave feedback to the project officer on which items in the brochure they didn't like and any changes they would make. "The brochures and posters were so well received that plans are now in the works for the development of a pap test brochure for American Indian women," Luebke said.~

IHS Policy Ensures American Indian Beliefs are Respected

By Houkje Ross

Many American Indians use traditional healers in addition to using Western medicine and Indian Health Service (IHS) facilities. Approximately 62 percent of Navajo patients have used a native healer in their lifetime and 39 percent have used native healers in the last year, according to research published in the *Archives of Internal Medicine* (Volume 158, November 9, 1998). "If they know the healer is there, they'll try it," said Wilbur Woodis, management analyst at IHS and information specialist at the Behavioral Health Alcoholism and Substance Abuse Program in the Albuquerque area IHS.

Health in relation to the Earth

For many American Indians/Alaska Natives (AI/ANs), and other aboriginal groups all over the world, health is seen in relation to the Earth, said Ervin W. Lewis, MD, director of the Behavioral Health Program in Albuquerque. Many native people see themselves as part of the Earth, not separate from it, Dr. Lewis said. This has a profound effect on the way native healers view and treat medical problems.

"If you are dehydrated, a Western doctor would tell you that drinking water will alleviate your sickness," said Woodis. "A traditional healer might bless you with a feather and water and tell you that you are not respecting the water. These are two very different ways of looking at health, but you get to the same place," Woodis said.

Helping American Indians locate healers

To ensure the cultural values, beliefs, and traditional healing practices of AI/ANs are respected and affirmed by IHS employees in all services and programs, in 1994 the agency developed a set of policies and procedures called the Traditional Cultural Advocacy Program (TCAP).

TCAP states IHS staff must inform its patients of their right to practice native religions and healing practices. When a patient or family member requests help in obtaining the service of a native practitioner or healer, every effort will be made to comply. These efforts might include contracting a native healer, providing space or privacy within a hospital room for a ceremony, or authorizing contract health care funds to pay for native health consultation. The policy also states the following:

- IHS area offices have the responsibility to consult and obtain the consent of AI/ANs in their area concerning each tribe's desire concerning the following: autopsy or other postmortem operations, disposition of body, disposal of a limb, disposal/burial of fetus.
- The patient's right to privacy must be respected. No IHS employee can interfere with a patient's private belief.
- IHS support, in whatever form, should not become a wedge that creates dependency or wrests control from chosen native health practitioners. IHS must work to maintain a system of healing which has a long history.

"Each tribe uses TCAP as it sees fit," Woodis said. The local communities decide where services will be provided, what those will be, who to go to for traditional healing, and what relationship they have with IHS. The agency can provide support to tribes through funding and resources, but it does not oversee the individual tribal use of the policy. This is in accordance with tribal self-governance regulations, Woodis said.

Woodis said health facilities in his area often point persons back to the community if they want to use traditional healing practices. A facility in Gallup, NM, has a hogan-style building—used for traditional healing purposes—on site. A hogan is a round building made of wood where life is propagated. Another IHS facility in Winslow, AZ, provides after-hours services for traditional healing ceremonies and a reimbursement program for traditional medicine costs.

For more information on the TCAP policy or other traditional medicine initiatives, contact Kermit Smith, (301) 443-1083 or Wilbur Woodis, (505) 248-4121. ~

Most common condition for which treatment is sought, in numbers (%)

Characteristic	Used Native Healer at least Once	Never Used a Native Healer
Age group		
18-29	46 (25)	29 (25)
30-49	64 (35)	45 (39)
50-65	44 (24)	30 (26)
66-90	31 (17)	10 (9)
Sex		
Female	108 (58)	72 (63)
Income		
<$5,000	60 (32)	36 (32)
5,000-9,999	35 (19)	27 (24)
10,000-19,999	54 (29)	32 (28)
>20,000	35 (19)	16 (14)
Education		
<High School	51 (28)	34 (30)
Some H.S.	22 (12)	25 (22)
High School	67 (36)	37 (32)
Some College	36 (19)	15 (13)
College/Grad.Sch	9 (5)	3 (3)
Needs Translator	31 (17)	14 (12)
No primary medical provider	96 (52)	54 (47)
Outpatient Visits in prior year		
1-5	69 (37)	42 (37)
6-10	52 (32)	34 (30)
11-20	38 (21)	25 (22)
21-50	19 (10)	13 (11)

Source: The IHS Provider, January 1999.

Associations & Organizations

American Medical Association
515 North State Street
Chicago, IL 60610
(312) 464-5000
http://www.ama-assn.org
Publications include:
- *Cultural Competence Compendium*. Provides over 400 pages of resources relating to cultural competency

American Medical Student Association
1902 Association Drive
Reston, VA 20191
(800) 767-2266
http://www.amsa.org
The Promoting, Reinforcing, and Improving Medical Education (PRIME) project has a curriculum on *Culture and Diversity*.

American Nurses Association
600 Maryland Ave. SW, Suite 100 West
Washington, DC 20024
(800) 274-4262
http://nursingworld.org

American Psychiatric Association
1400 K St. NW
Washington, DC 20005
(202) 682-6000
http://www.psych.org
Provides curricula for care of Hispanics, American Indians and Alaska Natives, women, and homosexuals.

American Public Health Association
801 I St NW
Washington, DC 20001
(202) 777-2742
http://www.apha.org
Holds an annual meeting in November on the latest in cross cultural communication, culturally competent resources and research, and the impact of spiritual practices and religious beliefs on health status.

Asian and Pacific Islander American Health Forum
942 Market St., Suite 200
San Francisco, CA 94102
(415) 954-9988
(703) 841-9128 (DC area office)
http://www.apiahf.org

Asian Community Mental Health Services
310 8th St. Suite 201
Oakland, CA 94607
(510) 451-6729
http://www.acmhs.org

Association of American Medical Colleges
2450 N St. NW
Washington, DC 20037-1127
(202) 828-0400
http://www.aamc.org

Association of Asian/Pacific Community Health Organizations
1440 Broadway, Suite 510
Oakland, CA 94612
(510) 272-9536
http://www.aapcho.org

Association of Clinicians for the Underserved
501 Darby Creek Rd., Suite 20
Lexington, KY 40509-1606
(606) 263-0046
http://www.clinicians.org

Bureau of Primary Health Care
Health Resources Service Administration
4350 East-West Highway
Bethesda, MD 20814
(301) 594-4100; Clearinghouse (800) 400-2742
http://www.bphc.hrsa.gov
Titles include:
- *Advanced Methodological Issues in Culturally Competent Evaluation for Substance Abuse Prevention;* Contact: BPHC Clearinghouse.
- *Cultural Competence for Health Care Professionals Working with African American Communities: Theory and Practice;* Contact: BPHC Clearinghouse.
- *Cultural Competence Issues for Social Workers Working in Ethnic/Racial Communities* (Available from the National Association of Social Workers Press).

Cross Cultural Health Care Program
Pacific Medical Clinics
1200 Twelfth Ave. South
Seattle, WA 98144
(206) 326-4161
http://www.xculture.org
Has bilingual medical glossaries, guides for interpreters, articles on interpreting, and videos.

Harvard Pilgrim Health Care, Inc.
Office of Diversity
10 Brookline Place West
Brookline, MA. 02146
(617) 730-7710
Provides interpreters to health centers and a course on how to work with interpreters.

Henry J Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025
(800) 656-4533
http://www.kff.org
Publications include:
- *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities* (Pub #1362)
- *Language Barriers to Health Care*. Papers from Henry J. Kaiser Foundation, *Journal of Health Care for the Poor and Underserved*, Vol. 9, 1998

Hispanic-Serving Health Professions Schools
1700 17th Street, NW Suite 405
Washington, D.C. 20009
(202) 667-9788
E-mail: HISHPS@aol.com

Indian Health Service
Parklawn Building, Rm 6-35
5600 Fishers Lane
Rockville, MD 20857
(301) 443-3593
http://www.ihs.gov

Inter-University Program for Latino Research
P.O. Box 8180
Austin, TX 78713
(512) 471-7100
http://iuplr.utexas.edu

Intercultural Cancer Council
PMB-C, 1720 Dryden
Houston, TX 77030
(713) 798-4617
http://icc.bcm.tmc.edu

Latino Coalition for a Healthy California
1535 Mission Street
San Francisco, CA 94103
(415) 431-7430
http://www.lchc.org

National Minority AIDS Council
1931 13th St. NW
Washington, DC 20009
(202) 483-6622
http://www.nmac.org

National Association of Black Social Workers
8436 West McNichols
Detroit, MI 48221
(313) 862-6700
http://www.nabsw.org

National Association of Hispanic Nurses
1501 16th Street, NW
Washington, DC 20036
(202) 387-2477
http://www.incacorp.com/nahn

National Black Nurses Association
8630 Fenton St., Suite 330
Silver Spring, MD 20910
(301) 589-3200
E-mail: nbna@erols.com

National Coalition of Hispanic Health and Human Services Organizations
1501 16th St NW
Washington, DC 20036
(202) 387-5000
http://www.cossmho.org

National Indian Health Board
1385 South Colorado Blvd., Suite A-707
Denver, CO 80222
(303) 759-3075
http://www.nihb.org

Refugee Health Issues Center
American Refugee Committee
2344 Nicollet Ave. South, Suite 350
Minneapolis, MN 55404
(612) 872-7060
http://www.archq.org

Resources for Cross Cultural Health Care
8915 Sudbury Rd.
Silver Spring, MD 20910
(301) 588-6051
http://www.diversityrx.org
Provides a national network of individuals and organizations in ethnic communities and health care organizations that offer technical assistance and information on cultural competency.

University Affiliated Programs

National Center for Cultural Competence
Georgetown Univ. Child Development Center
3307 M Street, NW Suite 401
Washington, DC 20007-3935
(800) 788-2066
http://www.dml.georgetown.edu/depts/pediatrics/gucdc

University of Minnesota
The Center for Cross Cultural Health
410 Church Street, Suite W227
Minneapolis, MN 55455
(612) 624-0996
http://www.crosshealth.com

University of Wisconsin School of Medicine
Center for the Study of Race and Ethnicity in Medicine
1224 Medical Sciences Center
1300 University Ave.
Madison, Wisconsin 53706
(608) 265-5996
http://www.wisc.edu/crem

New York University School of Medicine
Office of Minority Affairs and Student Services
Schwartz Lecture Hall 550 First Ave.
New York, NY 10016
(212) 263-8949
http://www.med.nyu.edu/som/minority.html
Titles include:
- *Cross-Cultural Care Giving in Maternal and Child Health: A Trainer's Manual*
- Health Belief Fact Sheets for Bangladeshi, Chinese, Haitian, Korean, Mexican, Puerto Rican, and West African immigrant groups

State University of New York
CultureMed; Institute of Technology Library
P.O. Box 3051
Utica, NY 13504
(315) 792-7250
http://www.sunyit.edu/library/culturedmed
Provides bibliographies on cultural competency for refugees from Bosnia, Russia, Asia; also provides information on transcultural nursing, and medical interpreters.

Portland State University
Research and Training Center on Family Support and Children's Mental Health
PO Box 751
Portland, OR 97207
(503) 725-4040
http://www.rri.pdx.edu
The Center has two projects related to cultural diversity: Multicultural Perspectives of Empowerment and Increasing Multicultural Parent Involvement. Titles include:
- *Cultural Competence Self-Assessment Questionnaire: A Manual for Users*, 1995
Developed to help child and family-serving agencies assess their cross-cultural strengths and weaknesses.

Interpreter Services Program
Univ of Massachusetts Memorial Medical Center
55 Lake Ave. North
Worcester, MA 01655
(508) 856-5793

University of Washington
EthnoMed website
Harborview Medical Center
http://www.hslib.washington.edu/clinical/ethnomed

Indiana University
Online Library provides information on transcultural and multicultural health
http://www.lib.iun.indiana.edu/transnurs.htm

University of Miami
http://www.library.miami.edu/staff/lmc
Online library provides information on sociocultural diversity and healthcare links

McGill University
Division of Social & Transcultural Psychiatry
Department of Psychiatry
1033 Pine Ave West
Montreal, Quebec H3A 1A1
Publishes quarterly journal; *Transcultural Psychiatry*
(514) 398-7302

University of North Carolina
Minority Health Project
http://www.minority.unc.edu
Provides annotated bibliographies relevant to health of racial and ethnic populations.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Office of Minority Health Resource Center
P.O. Box 37337
Washington DC 20013-7337

Official Business
Penalty for Private Use $300

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Closing the Gap

Conferences: Year 2000

February 17-19: Transcultural Nursing Society, (Southern Regional Chapter) 3rd Annual Conference. *Transcultural Nursing in the New Millennium.* Mulberry Inn, Savannah, GA. Sponsored by Georgia Southern University, Medical College of Georgia, and the University of Tennessee. Contact: Sharon Pratt, (912) 871-1928; stpratt@gsums2.cc.GaSoU.edu.

February 18-20: 4th Annual National Hispanic Medical Association Conference. *Eliminating Health Disparities in Health for Hispanics: A Call to Action*. L'EnFant Plaza, Washington, DC. Contact: NHMA, (202) 265-4297.

March 22-28: National Association of Community Health Centers (NACHC), *2000 Policy and Issues Forum*. Washington Hilton and Towers, Washington, DC. Call (202) 659-8008. For Hotel Reservations call: (202) 483-3000.

April 14-16: Sisters Network Inc.'s 2nd Annual National African American Breast Cancer Conference. Renaissance Concourse Hotel, Atlanta. Contact: (713) 781-0255.

April 26-29: 15th Annual Educational Conference, Exhibition and Business Meeting: Strategies for Maintaining Health Care in the New Millennium. Sponsored by the National Association of Health Services Executives. Hyatt Regency Hotel Houston, TX. Call (202) 628-3952 or e-mail NAHSE@compuserve.com

April 29-May 2: Community-Campus Partnerships for Health, 4th Annual Conference. *From Community-Campus Partnerships to Capitol Hill: A Policy Agenda for Health in the 21st Century.* Washington, DC. Contact: (415) 476-7081 or e-mail: sarena@u.washington.edu

May 4-7: National Farmworker Health Conference. Sponsored by the National Association of Community Health Centers. Portland Marriott Downtown. Portland, Oregon. Call: NACHC (202) 659-8008. For hotel reservations, call (503) 226-7600.

May 5-7: International Parent-to-Parent Conference 2000. *Pioneering Spirit—Blazing New Trails*. Sponsored by the Parent Network, University of Nevada. Includes strategies for addressing challenges of diversity & culture. Reno Hilton Casino and Resort. Contact: Cheryl Dinnell, (775) 784-4921, ext. 2352.

May 25-27: National Rural Health Association's 23rd Annual Conference. New Orleans, LA. Contact: NRHA, (816) 756-3140.